

# Knee Evaluation Rt Lt

**DDN:** \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Occupation: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Usual activity/ pastime: \_\_\_\_\_

Positions held for long time: \_\_\_\_\_

HPI: \_\_\_\_\_  
\_\_\_\_\_

Evolution des symptômes : Improving: \_\_\_\_\_ Worsening: \_\_\_\_\_ Same: \_\_\_\_\_

Traitements antérieur :  aucun \_\_\_\_\_

Objectifs du client :

Dans les limites de la normale (DLN)	AVQ	Indép.	Ass.	details	AVD	Indép.	Ass	details
	Hygiène				Squat			
	Alimentation				debout			
	Transferts				Marche			
	Déplacements				autre			

Rapports d'examens (Rayons-X, RMI, EMG,...) :  see intake  aucun \_\_\_\_\_

Allergies :  voir intake  aucune \_\_\_\_\_

Antécédents (pertinent à la lésion actuelle) :  see intake  aucune \_\_\_\_\_

Affections associées (autres problèmes qui peuvent influencer):  see intake  aucune \_\_\_\_\_

Meds:  see intake  aucune \_\_\_\_\_

Pain:

1-10 scale: \_\_\_\_\_ Duration: \_\_\_\_\_ Periodic: \_\_\_\_\_ Constant: \_\_\_\_\_ Intermittent: \_\_\_\_\_

Worse with: \_\_\_\_\_

Better with: \_\_\_\_\_

Radiation: \_\_\_\_\_ P&N: \_\_\_\_\_ Numbness: \_\_\_\_\_ Sleeping Position: \_\_\_\_\_

Deep: \_\_\_\_\_ Superficial: \_\_\_\_\_ Shooting: \_\_\_\_\_ Burning: \_\_\_\_\_ Aching: \_\_\_\_\_

Location:  see diagram \_\_\_\_\_

Posture/Observation:

Leg Length: \_\_\_\_\_

Spasm: \_\_\_\_\_

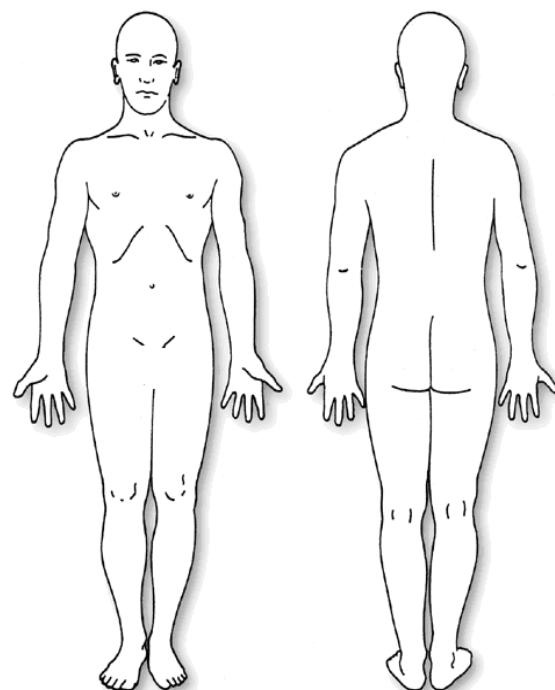
Q-Angle: \_\_\_\_\_

Knees (genou): \_\_\_\_\_

Longitudinal Arch: \_\_\_\_\_

Transverse Arch: \_\_\_\_\_

Leg Dominance: \_\_\_\_\_



Oedeme	DROIT	GAUCHE

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	<b>Right</b>	<b>AROM</b>	<b>Left</b>	<b>Right</b>	<b>PROM</b>	<b>Left</b>	<b>Right</b>	<b>Res.ROM</b>	<b>Left</b>
<b>Knee</b>	<b>Flx</b>								
	<b>Ext</b>								
	<b>IR</b>								
	<b>ER</b>								

Hip:  AROM & PROM complet  Force 5/5 \_\_\_\_\_

Ankle:  AROM & PROM complet  Force 5/5 \_\_\_\_\_

<b>Souplesse Musculaire</b>	<b>Right</b>	<b>Left</b>
Iliopsoas (Thomas test)	<input type="checkbox"/> +ve <input type="checkbox"/> -ve other:	<input type="checkbox"/> +ve <input type="checkbox"/> -ve other:
Quadriceps (Ely's test)	<input type="checkbox"/> +ve <input type="checkbox"/> -ve other:	<input type="checkbox"/> +ve <input type="checkbox"/> -ve other:
Hamstrings (SLR)		
Adductors (passive abd hip)		
TFL-ITBand (Ober's test)	<input type="checkbox"/> +ve <input type="checkbox"/> -ve other:	<input type="checkbox"/> +ve <input type="checkbox"/> -ve other:
Gastrocnemius (passive DF)		
Soleus (passive DF with knee flx)		

**Other:** \_\_\_\_\_

**Special Tests:**

<b>Ligament-Meniscus</b>	<b>Right</b>	<b>Left</b>	<b>Patella</b>	<b>Right</b>	<b>Left</b>
MCL-Valgus			Apprehension		
LCL-Varus			Crepitation		
ACL-Lachmann			Chondromalacia		
ACL-Ant.Shift			<b>Swelling:</b>		
PCL-Post.Shift			Brush Test		
McMurray			Ballotable		

**Other:** \_\_\_\_\_

<b>Reflexes:</b>	<b>Right</b>	<b>Left</b>	<b>Right</b>	<b>Left</b>
Patellar			Achilles	
Hamstring				

**Dermatomes:**

L1-2: \_\_\_\_\_ L3: \_\_\_\_\_ L4: \_\_\_\_\_ L5: \_\_\_\_\_ S1: \_\_\_\_\_

**Joint Play:** \_\_\_\_\_

**Functional Activities:**

Ambulation: \_\_\_\_\_

Stairs: \_\_\_\_\_

Squat: \_\_\_\_\_

Running: \_\_\_\_\_

Other: \_\_\_\_\_

Palpation: \_\_\_\_\_